Steps to Complete DMR Amendment Excel Files

Save file with new name
All tables of data can be seen on the "lookup tables" tab
All sheets are protected. Left and right arrows used to navigate within form
Protection can be remove- at your own peril! Use "tools","protection","unprotect sheet".
If you find formula errors of other glitches, let me know!
Sandon.Shepard@state.ma.us
Good Luck!

Step	Tab	Action
1	DATA	Enter Provider info
2	DATA	For Contract number, break last 6 digits before "DMR00000" into two parts
3	DATA	First two indicate Region and Area
4	DATA	Next four are unique contract identifiers
5	DATA	Type first two into "Reg/Area" box
6	DATA	Type next four into "seq#" box
7	DATA	Enter Unit Code (Regional Contract Office will provide correct number
8	DATA	Enter region number- address will populate automatically
9	DATA	Enter relevant contact information as indicated
10	DATA	Dates:
11	DATA	Box 1,3,5- always the original start date of contract
12	DATA	only enter in box 1
13	DATA	box 2 First year of contract end date
14	DATA	box 4 Current year end date- FY 2006 = June 30, 2006
15	DATA	box 6 New year end date- FY 2007= June 30, 2007
16	DATA	box 9 Total contract end date-> final after all renewals
17	Program Data	is color coded- colors on program budget match prog, budget and rate calc tabs
18	Program D	Provider info and DMR info automatically carries forward
19	Program D	Can use up to 6 program budgets
20	Program D	If program budget is cost reimbursement, put "x" in box next to program
21	Program D	Fill in Activity code
22	Program D	Fill in UFR code for that program
23	Program D	Fill in CFDA number (only for federally funded programs)
24	Program D	Fill in program name, address, city/town, state, zip and zip 4
25	Program D	If not using other program budget info (programs 2-6), leave blank
26	Program D	In Program Summary Section, indicate with "x" active budgets
27	Prog 1	In fiscal terms, indicate Option 3, budget type- either unit or cost reimb
28	Prog 1	Ready Payment amount calculates at 1/24, round down to lower $1,000
29	Budget 1	Enter UFR titles for all positions funded in contract
30	Budget 1	Enter relevant FTE numbers and dollar amounts for each UFR title
31	Budget 1	Off to the right of the form, fields calculate average salaries- check for quality of data
32	Budget 1	Enter payroll tax and fringe amounts
33	Budget 1	Enter Occupancy costs as needed
34	Budget 1	Enter UFR titles and expenses for Other Direct Care items
35	Budget 1	For vehicle expenses:
36	Budget 1	use 208 for Contracted transportation
37	Budget 1	208.1 for vehicle expenses (lease, operating expenses)
38	Budget 1	208.2 for vehicle depreciation
39	Budget 1	Enter Program support and Direct admin expenses
40	Budget 1	Enter Agency administrative expense (indirect cost)
41	Budget 1	Enter Board approved capitalization level at *** at the bottom of the page
42	Rate 1	Enter offsets (occupancy, non- occupancy, and other)
43	Rate 1	Enter program capacity as a number
44	Rate 1	Enter Type of unit
45	Rate 1	Enter share of program being purchased under this contract (100% or less)
46	Rate 1	Number of units purchased ties to % (above). Modify % to reach desired number of units.
47	Rate 1	Enter utilization factor (standard = 85%)
48	Rate 1	On right, calculation shows amt. remove for whole unit max ob (100% DMR purchase only)

49	Repeat Steps 20-48 as necessary for other programs (2-6)	
50	Attach A	Fill in sections- add pages as necessary
51	Amend	Enter Current maximum obligation of contract- same as final from FY 2006
52	Amend	Select Amendment type- for 2007 renewals, "Amendment to Exercise Option to Renew"
53	Amend	Check relevant boxes for performance, max ob, duration, rates and dates
54	Amend	For renewals, Max ob, rate and dates should always be selected
55	Amend	Enter reason for amendment. Provide details as necessary
56	Print all pages	
57	Sign	Return to Regional Contract Office

PROVIDER INFORMATION

Corporate Name:					
Address:					
City / Town:					
State:		Zip:		Zip + 4:	
Vendor Code (VCC#)					
FEIN					
Corporate Phone: Area		Number			
Corporate Fax #: Area		Number			
Contracts Contact:					
Contact Phone: Area		Number			

AGENCY INFORMATION

Contract Info:	CT/RPO	FY	Reg/Area	Seq #
		7		
Unit Code				
Contract #:	710007000000DMR00000			
Department Name:	Department of Mental Retardation			
Region Number				
Contracting Entity:	#N/A			
Address:	#N/A			
City / Town:	#N/A			
State: MA	Zip Code: #N/A			
Department Contact:				
Contact Phone: Area	Number			

CONTRACT DURATIONS

Dates of Service:	Fiscal Year:	**2007**
1. Original Start Date:	2. First Year End Date:	
3. Current Year Start Date:	4. Current Year End Date:	
January 0, 1900		
5. New Year Start Date:	6. New Year End Date:	
January 0, 1900		

AMENDMENT NUMBER: 07_ **00**	7. Total Contract End Date:
RFR Reference #:	

PROVIDER INFORMATION					
Corporate Name:					
Address:					
City / Town:					
State:		Zip:		Zip + 4:	

CONTRACT INFORMATION				
Contract Info:	CT/RPO	FY	Area/Reg	Seq #
	0000	7	00	0
Contract #:	710007000000DMR00000			

AGENCY INFORMATION			
Department Name:	Department of Mental Retardation		
Region Number	0		
Contracting Entity:	#N/A		
Address:	#N/A		
City / Town:	#N/A		
State:	MA	Zip Code:	#N/A
Department Contact:	0		
Contact Phone: Area	0	Number	000 - 0000

AMENDMENT NUMBER: 07 **00**

Fill in relevant information for each program budget used. If not using all 6 program budgets, leave unused ones blank.

000-000-0000

PROGRAM 1		If Unit Rate, leave Blank, Cost Reim, enter X->			
Activity Code:					
Activity Code Name:	#N/A				
UFR Program Code:		CFDA #: (If Federal Funds)			
Program Name:					
Program Address:					
City / Town:					
State:		Zip:		Zip + 4:	

PROGRAM 2		If Unit Rate, leave Blank, Cost Reim, enter X->			
Activity Code:					
Activity Code Name:	#N/A				
UFR Program Code:		CFDA #: (If Federal Funds)			
Program Name:					
Program Address:					
City / Town:					
State:		Zip:		Zip + 4:	

PROGRAM 3		If Unit Rate, leave Blank, Cost Reim, enter X->			
Activity Code:					
Activity Code Name:	#N/A				
UFR Program		CFDA #: (If Federal			
Program Name:					
Program Address:					
City / Town:					
State:		Zip:		Zip + 4:	

PROGRAM 4		If Unit Rate, leave Blank, Cost Reim, enter X->			
Activity Code:					
Activity Code Name:	#N/A				
UFR Program Code:		CFDA #: (If Federal Funds)			
Program Name:					
Program Address:					
City / Town:					
State:		Zip:		Zip + 4:	

PROGRAM 5		If Unit Rate, leave Blank, Cost Reim, enter X->			
Activity Code:					
Activity Code Name:	#N/A				
UFR Program Code:		CFDA #: (If Federal Funds)			
Program Name:					
Program Address:					
City / Town:					
State:		Zip:		Zip + 4:	

PROGRAM 6		If Unit Rate, leave Blank, Cost Reim, enter X->			
Activity Code:					
Activity Code Name:	#N/A				
UFR Program		CFDA #: (If Federal			
Program Name:					
Program Address:					
City / Town:					
State:		Zip:		Zip + 4:	

Program Summary

Check if box with "X" if Active on this contract		Amount
Program 1		-
Program 2		-
Program 3		-
Program 4		-
Program 5		-
Program 6		-
Maximum Obligation for this contract		-

DOC ID NUMBER: 0 DMR 710007000000DMR00000 **Object Code**

COMMONWEALTH OF MASSACHUSETTS
STANDARD CONTRACT AMENDMENT FORM

This Amendment Form is jointly issued by the Executive Office for Administration and Finance (ANF), the Office of the Comptroller (CTR) and the Operational Services Division (OSD) for use by all Commonwealth Departments. Any changes or electronic alterations, by either the Department or the Contractor, to the official printed language of this form as published by ANF, CTR and OSD shall be void. Contract Amendments must be authorized as part of the original Contract procurement and must be executed contemporaneously with the need for the Contract Amendment and prior to the scheduled termination date of this Contract.

CONTRACTOR NAME:	**DEPARTMENT NAME:**
Vendor Code: _____	Department of Mental Retardation
ADDRESS: , -	**ADDRESS:** #N/A #N/A #N/A

CURRENT CONTRACT INFORMATION

Current Doc. ID Number of Contract Being Amended: 0 DMR 610006000000DMR00000

Current Total Contract Dates: **START:** *January 0, 1900* **TERMINATION:** *January 0, 1900*
(Includes Original Contract Start Date and Amendment):

Current Total Maximum Obligation of Contract ***(Inclusive of Previous Amendments To Date) :*** **$** _____
(indicate "NA" if Contract is a Rate Contract, Statewide Contract or Qualified List Contract that does not contain a Maximum Obligation.)

CHOOSE ONE AMENDMENT COLUMN BELOW, either "STANDARD AMENDMENT "*OR* " AMENDMENT TO EXERCISE OPTION TO RENEW " and check off any applicable amendments under that column.

☐ **STANDARD AMENDMENT** *(Check all that apply)*	☐ **AMENDMENT TO EXERCISE OPTION TO RENEW** *(Check all that apply)*
☐ **Amendment To Contract Performance**	☐ **Amendment To Contract Performance**
☐ **Amendment To Contract Maximum Obligation**	☐ **Amendment To Contract Maximum Obligation**
☐ **Amendment To Contract Budget OR Rates**	☐ **Amendment To Contract Budget OR Rates**
☐ **Amendment To Contract Dates of Performance**	☐ **Amendment To Contract Dates of Performance**
☐ **Other:** ***(Explain)***	☐ **Other:** ***(Explain)***

DESCRIPTION OF REASON FOR AMENDMENT: *(Attach all relevant documentation detailing amendments(s)):*

Annual renewal of contract. No changes to services.

NEW CONTRACT INFORMATION *(indicate "N/A" if not applicable or "N/C" for no change):*

New Total Contract Dates (*Includes Original Contract Start Date and Amendments):* **START:** N/C **TERMINATION:** N/C

Amount of Amendment Change *(if applicable):* **$** 0 .00

New Total Maximum Obligation of Contract: **$** - *(Includes Total of "Current Total Maximum Obligation" indicated above and the "Amount of Amendment Change". Indicate "N/A" if Contract is a Rate Contract, Statewide Contract or Qualified List Contract that does not contain a Maximum Obligation) .*

IN WITNESS WHEREOF: the Department and the Contractor certify under the pains and penalties of perjury that this Amendment Form and any information contained herein, or attached hereto, is complete and accurate and complies with all applicable laws and regulations, and is subject to its associated Contract, as evidenced by the execution by their authorized signatories as of the last date below:

FOR THE CONTRACTOR:	**FOR THE DEPARTMENT:**
X: _____ **(Signature)**	**X:** _____ **(Signature)**
NAME: _____	**NAME:** _____
TITLE: _____	**TITLE:** _____
DATE: _____	**DATE:** _____

The Department must file the original record copy of any Contract Amendment with the original record copy of the Contract being amended. Record copies will be located at either OSC, OSD or the Department (if the Department has been approved for Contract Delegation authority) .

Issued 5/12/97

ATTACHMENT A: RENEWAL/AMENDMENT SUMMARY FORM

Contract Number	710007000000DMR00000			Amendment Number	0
Renewal Year	2007	Renewal Dates of Service: From	1/1/1900	To	1/0/1900

CONTRACT SUMMARY

Provider Name			
Program Name	0	Activity Code:	
Program Locations			

Summarize the program narrative which may include information regarding the program's service elements and/or its client profile. Incorporate any program changes which occurred during the amendment process and/or any changes made in the contract renewal negotiations for this fiscal year.

Highlight any significant programmatic or fiscal changes

Identify any modifications to the outcome measures of performance based objectives

FY 2007 Program Number 1

ATTACHMENT 1 : PROGRAM COVER PAGE

PROGRAM INFORMATION

Contractor / Provider Name :	Department Name : Department of Mental Retardation	
Program Type : #N/A	Document ID # : **710007000000DMR00000**	
Program Name : 0	Vendor Code Number :	CFDA # (If Federal Funds) 0
Program Address : 0	MMARS Program Code : 0	UFR Program # : 0
City / State / Zip : , 00000-	Other Reference Information (For Information Purposes Only) :	
Contact Person : **0** Telephone : **000-000-0000**	Contact Person : **0** Telephone : **000-000-0000**	

RFR INFORMATION : ☐ Attached ☒ RFR Reference # : **0**

☐ legislative exemption ☐ emergency ☐ collective purchase ☐ interim ☒ amendment

SCOPE OF SERVICES : ☐ Bidders Response Attached ☐ Description of Services Attached

TOTAL ANTICIPATED CONTRACT DURATION **January 0, 1900** to **January 0, 1900**

INITIAL DURATION : **January 0, 1900** to **January 0, 1900**

OPTIONS TO RENEW : _____ options to renew for _____ year (s) each option

FISCAL TERMS

PRICE ESTABLISHED THROUGH : (CHECK 1 , 2 , OR 3)

☐ **OPTION 1 : PRICE AGREEMENT** (list price)
$ _____
rate regulation (if any) _____

☐ **OPTION 2 : SUMMARY BUDGET** (* lines only)
☐ unit rate
☐ cost reimbursement
☐ other _____

☐ **OPTION 3 : COMPLETE BUDGET**
☐ unit rate
☐ cost reimbursement
☐ other _____

FUNDING SUMMARY

Prior Years FY	Prior Years Amount	Current Year FY	Current Year Amount	Future Years FY	Future Years Amount
	-	2007	-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
Total	-	**Total**	-	**Total**	-

Multi - Year Total : **$ 0.00**

CURRENT MAX OBLIGATION : $ 0.00.

UNIT RATE : $ - per **Bed / Day**

 # BILLABLE UNITS : -

ADDITIONAL PAYMENT OR PRICE SPECIFICATIONS :

Ready Payment Amount for SM01 Schedule = **$ 0.00**

Capital Budget Amount **$** 0.00

PURCHASE OF SERVICE - ATTACHMENT 3 : FISCAL YEAR PROGRAM BUDGET (# 1)

2007		0
FY	CONTRACTOR NAME	CFDA # (If Federal Funds)

Program Name :	Document ID # :	MMARS Code:	Amendment #:	Program Type :	UFR Prog. # :
0	710007000000DMR00000	0	0	#N/A	0

UFR Title #	Program Component Direct Care / Program Support Staff Overtime/Shift Differential & Relief (UFR Titles 101-141)	Current		Amended / Change		New		COST REIMBURSEMENT ONLY		
		FTE	Amount	FTE	Amount	FTE	Amount	** Offset	Source	Reimbursable Cost
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
	SUBTOTAL STAFF	-	-	-	-	-	-	-		-
150	Payroll Taxes	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
151	Fringe Benefits	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
T	**Total Direct Care / Program Staff**	-	-	-	-	-	-	-		-
Title	**OCCUPANCY**									
301	Program Facilities		-		-		-	-		-
***390	Fac. Oper/Main/Furn		-		-		-	-		-
T	**Total Occupancy**		-		-		-	-		-
UFR TITLE #	Other Direct Care / Program Support		**Amount**		**Amount**		**Amount**	**Offset**	**Source**	**Reimbursable Cost**
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
T	**Total Other Direct Care / Program Support**	-	-	-	-	-	-	-		-
Title	**Direct Admin Expenses**									
216	Program Support		-		-		-	-		-
***410 & 390	Other Direct Administrative Expenses		-		-		-	-		-
T	**Total Direct Admin Expenses**		-		-		-	-		-
T	**Subtotal Program Costs**		-		-		-	-		-
T	Agency Admin. Support Allocation	#DIV/0!	-		-	#DIV/0!	-	-		-
T	**PROGRAM TOTAL**	-	-	-	-	-	-	-		-

Commercial Fee, if applicable (for informational purposes only; not to be included in the price paid by the Commonwealth) % ____ $ ____ : **N/A for Cost Reimbursement**

** Non-reimbursable costs must be shown on the detail Attachment 5 when the program is subject to the provisions of Federal OMB Circular A - 122 and / or 808 CMR 1.00.

**A. $ ____ Subtotal of offsets which are for non-reimbursable costs.

*** Contractor's Board approved capitalization level relative to any negotiated expense costs in lines 208, 215, 390 or 410 is $ ____

PURCHASE OF SERVICE

ATTACHMENT 4: RATE CALCULATION / MAXIMUM OBLIGATION CALCULATION PAGE

Program Number 1

FY :	Contractor Name :	Program Name :	CFDA # (If Federal Funds)
2007		**0**	**0**

Document ID # :	MMARS Code:	Amendment #: (If Applicable)	Program Type :	UFR Prog. # :
710007000000DMR00000	**0**	**00**	**#N/A**	**0**

UNIT RATE CALCULATION

1 . **Program Total Costs** **$** -

	Source	Amount
2a.(1) Program Offsets		-
Applied to occupancy and meals		-
2a.(2) Program Offsets		-
Applied to non-occupancy and meals		-
2a.(c) Other Offsets		-
		-
2b. Offsets for Non-Reimbursable Costs:		-

NOTE: Total reimbursable costs listed in line **2b** must be detailed on **ATTACHMENT 5** .

2 . SUBTOTAL OFFSETS (**Line 2A + Line 2B**) **($** - **)**

3 . Net Adjusted Program Costs (**LINE 1 minus LINE 2**) **$** -

4 . Total Program Capacity [0] 0 (# of Units) Bed / Day (Type of Unit)

5 . Share of Total Capacity Being Purchased by Contract - (# of units) 100.00% **(% of line 4)**

6 . Negotiated Utilization Factor, if any **85.00%**

7 . Adjusted Capacity Used To Establish Price (**LINE 4 x LINE 6**) - (# of Units)

8 . Unit Rate **(LINE 3 / LINE 7)** **$** -

9 . Maximum # of Billable Units (**LINE 5 x LINE 6**) -

OTHER PRICE CALCULATION METHOD

10 . Enter relevant information :

MAXIMUM OBLIGATION CALCULATION

11 . FOR UNIT RATE : (**LINE 8 x LINE 9**)
FOR OTHER PRICE CALCULATION METHOD, ENTER OBLIGATION FROM LINE 10
FOR COST REIMBURSEMENT : ENTER REIMBURSABLE COST TOTAL FROM PROGRAM BUDGET

$ -

12 . Invoice Offset

Source	Amount
	-
	-
	-

12 . Subtotal **($** - **)**

13 . Program Maximum Obligation - Non - Capital Budget **(LINE 11 minus LINE 12)** **$** -

14 . Capital Budget (From Capital Budget Form), if applicable **$** -

15 . **TOTAL MAXIMUM OBLIGATION for Program (LINE 13 + Line 14)** **$** -

FOR INFORMATION ONLY : Other Revenue Sources (Only if % In LINE 5 is less than 100 %)

SOURCE	AMOUNT

FY 2007 Program Number 2

ATTACHMENT 1 : PROGRAM COVER PAGE

PROGRAM INFORMATION

Contractor / Provider Name :	Department Name : Department of Mental Retardation	
Program Type : #N/A	Document ID # : **710007000000DMR00000**	
Program Name : 0	Vendor Code Number :	CFDA # (If Federal Funds) 0
Program Address : 0	MMARS Program Code : 0	UFR Program # : 0
City / State / Zip : , 00000-	Other Reference Information (For Information Purposes Only) :	
Contact Person : **0** Telephone : **000-000-0000**	Contact Person : 0 Telephone : 000-000-0000	

RFR INFORMATION : ☐ Attached ☒ RFR Reference # : 0

☐ legislative exemption ☐ emergency ☐ collective purchase ☐ interim ☒ amendment

SCOPE OF SERVICES : ☐ Bidders Response Attached ☐ Description of Services Attached

TOTAL ANTICIPATED CONTRACT DURATION **January 0, 1900** to **January 0, 1900**

INITIAL DURATION : **January 0, 1900** to **January 0, 1900**

OPTIONS TO RENEW : _____ options to renew for _____ year (s) each option

FISCAL TERMS

PRICE ESTABLISHED THROUGH : (CHECK 1 , 2 , OR 3)

☐ **OPTION 1 : PRICE AGREEMENT** (list price)
$ _____
rate regulation (if any) _____

☐ **OPTION 2 : SUMMARY BUDGET** (* lines only)
- ☐ unit rate
- ☐ cost reimbursement
- ☐ other _____

☐ **OPTION 3 : COMPLETE BUDGET**
- ☐ unit rate
- ☐ cost reimbursement
- ☐ other _____

FUNDING SUMMARY

Prior Years FY	Prior Years Amount	Current Year FY	Current Year Amount	Future Years FY	Future Years Amount
	-	2007	-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
Total	-	**Total**	-	**Total**	-

Multi - Year Total : **$ 0.00**

CURRENT MAX OBLIGATION : $ 0.00.

UNIT RATE : $ - per **Bed / Day**

 # BILLABLE UNITS : -

ADDITIONAL PAYMENT OR PRICE SPECIFICATIONS :

Ready Payment Amount for SM01 Schedule = **$ 0.00**

Capital Budget Amount **$** 0.00

PURCHASE OF SERVICE - ATTACHMENT 3 : FISCAL YEAR PROGRAM BUDGET (# 2)

2007 — FY

CONTRACTOR NAME

0 — CFDA # (If Federal Funds)

Program Name :	Document ID # :	MMARS Code:	Amendment #:	Program Type :	UFR Prog. # :
0	710007000000DMR00000	0	0	#N/A	0

UFR Title #	Program Component Direct Care / Program Support Staff Overtime/Shift Differential & Relief (UFR Titles 101-141)	Current FTE	Current Amount	Amended / Change FTE	Amended / Change Amount	New FTE	New Amount	COST REIMBURSEMENT ONLY ** Offset	Source	Reimbursable Cost
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
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-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
	SUBTOTAL STAFF	-	-	-	-	-	-	-		-
150	Payroll Taxes	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
151	Fringe Benefits	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
T	**Total Direct Care / Program Staff**	-	-	-	-	-	-	-		-
Title	**OCCUPANCY**									
301	Program Facilities		-		-		-	-		-
***390	Fac. Oper/Main/Furn		-		-		-	-		-
T	**Total Occupancy**		-		-		-	-		-
UFR TITLE #	Other Direct Care / Program Support		**Amount**		**Amount**		**Amount**	**Offset**	**Source**	**Reimbursable Cost**
	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
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-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
T	**Total Other Direct Care / Program Support**	-	-	-	-	-	-	-		-
Title	**Direct Admin Expenses**									
216	Program Support		-		-		-	-		-
***410 & 390	Other Direct Administrative Expenses		-		-		-	-		-
T	**Total Direct Admin Expenses**		-		-		-	-		-
T	**Subtotal Program Costs**		-		-		-	-		-
T	Agency Admin. Support Allocation	#DIV/0!	-		-	#DIV/0!	-	-		-
T	**PROGRAM TOTAL**	-	-	-	-	-	-	-		-

Commercial Fee, if applicable (for informational purposes only; not to be included in the price paid by the Commonwealth) % ____ $ ____ : **N/A for Cost Reimbursement**

** Non-reimbursable costs must be shown on the detail Attachment 5 when the program is subject to the provisions of Federal OMB Circular A - 122 and / or 808 CMR 1.00.

**A. $ ____ Subtotal of offsets which are for non-reimbursable costs.

*** Contractor's Board approved capitalization level relative to any negotiated expense costs in lines 208, 215, 390 or 410 is $ ____

PURCHASE OF SERVICE

ATTACHMENT 4: RATE CALCULATION / MAXIMUM OBLIGATION CALCULATION PAGE

Program Number 2

FY :	Contractor Name :	Program Name :	CFDA # (If Federal Funds)
2007		**0**	**0**

Document ID # :	MMARS Code:	Amendment #: (If Applicable)	Program Type :	UFR Prog. # :
710007000000DMR00000	**0**	**00**	**#N/A**	**0**

UNIT RATE CALCULATION

1 . **Program Total Costs** **$** -

	Source	Amount
2a.(1) Program Offsets		-
Applied to occupancy and meals		-
2a.(2) Program Offsets		-
Applied to non-occupancy and meals		-
2a.(c) Other Offsets		-
		-
2b. Offsets for Non-Reimbursable Costs:		-

NOTE: Total reimbursable costs listed in line **2b** must be detailed on **ATTACHMENT 5** .

2 . SUBTOTAL OFFSETS (**Line 2A + Line 2B**) **($** - **)**

3 . Net Adjusted Program Costs (**LINE 1 minus LINE 2**) **$** -

4 . Total Program Capacity [0] 0 (# of Units) Bed / Day (Type of Unit)

5 . Share of Total Capacity Being Purchased by Contract - (# of units) 100.00% **(% of line 4)**

6 . Negotiated Utilization Factor, if any **85.00%**

7 . Adjusted Capacity Used To Establish Price (**LINE 4 x LINE 6**) - (# of Units)

8 . Unit Rate **(LINE 3 / LINE 7)** **$** -

9 . Maximum # of Billable Units (**LINE 5 x LINE 6**) -

MAXIMUM OBLIGATION CALCULATION

11 . FOR UNIT RATE : (**LINE 8 x LINE 9**)
FOR OTHER PRICE CALCULATION METHOD, ENTER OBLIGATION FROM LINE 10
FOR COST REIMBURSEMENT : ENTER REIMBURSABLE COST TOTAL FROM PROGRAM BUDGET **$** -

12 . Invoice Offset

Source	Amount
	-
	-
	-

12 . Subtotal **($** - **)**

13 . Program Maximum Obligation - Non - Capital Budget **(LINE 11 minus LINE 12)** **$** -

14 . Capital Budget (From Capital Budget Form), if applicable **$** -

15 . **TOTAL MAXIMUM OBLIGATION for Program (LINE 13 + Line 14)** **$** -

FOR INFORMATION ONLY : Other Revenue Sources (Only if % In LINE 5 is less than 100 %)

SOURCE	AMOUNT

FY 2007 Program Number 3

ATTACHMENT 1 : PROGRAM COVER PAGE

PROGRAM INFORMATION

Contractor / Provider Name :	Department Name : Department of Mental Retardation	
Program Type : #N/A	Document ID # : **710007000000DMR00000**	
Program Name : 0	Vendor Code Number :	CFDA # (If Federal Funds) 0
Program Address : 0	MMARS Program Code : 0	UFR Program # : 0
City / State / Zip : , 00000-	Other Reference Information (For Information Purposes Only) :	
Contact Person : **0** Telephone : **000-000-0000**	Contact Person : 0 Telephone : 000-000-0000	

RFR INFORMATION : ☐ Attached ☒ RFR Reference # : 0

☐ legislative exemption ☐ emergency ☐ collective purchase ☐ interim ☒ amendment

SCOPE OF SERVICES : ☐ Bidders Response Attached ☐ Description of Services Attached

TOTAL ANTICIPATED CONTRACT DURATION **January 0, 1900** to **January 0, 1900**

INITIAL DURATION : **January 0, 1900** to **January 0, 1900**

OPTIONS TO RENEW : _____ options to renew for _____ year (s) each option

FISCAL TERMS

PRICE ESTABLISHED THROUGH : (CHECK 1 , 2 , OR 3)

☐ **OPTION 1 : PRICE AGREEMENT** (list price)
$ _____
rate regulation (if any) _____

☐ **OPTION 2 : SUMMARY BUDGET** (* lines only)
☐ unit rate
☐ cost reimbursement
☐ other _____

☐ **OPTION 3 : COMPLETE BUDGET**
☐ unit rate
☐ cost reimbursement
☐ other _____

FUNDING SUMMARY

Prior Years FY	Prior Years Amount	Current Year FY	Current Year Amount	Future Years FY	Future Years Amount
	-	2007	-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
Total	-	**Total**	-	**Total**	-

Multi - Year Total : **$ 0.00**

CURRENT MAX OBLIGATION : $ 0.00.

UNIT RATE : $ - per **Bed / Day**

 # BILLABLE UNITS : -

ADDITIONAL PAYMENT OR PRICE SPECIFICATIONS :

Ready Payment Amount for SM01 Schedule = **$ 0.00**

Capital Budget Amount $ 0.00

PURCHASE OF SERVICE - ATTACHMENT 3 : FISCAL YEAR PROGRAM BUDGET (# 3)

2007 | 0

FY | CONTRACTOR NAME | CFDA # (If Federal Funds)

Program Name :	Document ID # :	MMARS Code:	Amendment #:	Program Type :	UFR Prog. # :
0	710007000000DMR00000	0	0	#N/A	0

UFR Title #	Program Component Direct Care / Program Support Staff Overtime/Shift Differential & Relief (UFR Titles 101-141)	Current FTE	Current Amount	Amended / Change FTE	Amended / Change Amount	New FTE	New Amount	COST REIMBURSEMENT ONLY ** Offset	Source	Reimbursable Cost
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
	SUBTOTAL STAFF	-	-	-	-	-	-	-		-
150	Payroll Taxes	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
151	Fringe Benefits	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
T	**Total Direct Care / Program Staff**	-	-	-	-	-	-	-		-
Title	**OCCUPANCY**									
301	Program Facilities		-		-		-	-		-
***390	Fac. Oper/Main/Furn		-		-		-	-		-
T	**Total Occupancy**		-		-		-	-		-
UFR TITLE #	Other Direct Care / Program Support		**Amount**		**Amount**		**Amount**	**Offset**	**Source**	**Reimbursable Cost**
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
T	**Total Other Direct Care / Program Support**	-	-	-	-	-	-	-		-
Title	**Direct Admin Expenses**									
216	Program Support		-		-		-	-		-
***410 & 390	Other Direct Administrative Expenses		-		-		-	-		-
T	**Total Direct Admin Expenses**		-		-		-	-		-
T	**Subtotal Program Costs**		-		-		-	-		-
T	Agency Admin. Support Allocation	#DIV/0!	-		-	#DIV/0!	-	-		-
T	**PROGRAM TOTAL**	-	-	-	-	-	-	-		-

Commercial Fee, if applicable (for informational purposes only; not to be included in the price paid by the Commonwealth) % ____ $ ____ : **N/A for Cost Reimbursement**

** Non-reimbursable costs must be shown on the detail Attachment 5 when the program is subject to the provisions of Federal OMB Circular A - 122 and / or 808 CMR 1.00.

**A. $ ____ Subtotal of offsets which are for non-reimbursable costs.

*** Contractor's Board approved capitalization level relative to any negotiated expense costs in lines 208, 215, 390 or 410 is $____

PURCHASE OF SERVICE

ATTACHMENT 4: RATE CALCULATION / MAXIMUM OBLIGATION CALCULATION PAGE

Program Number 3

FY :	Contractor Name :	Program Name :	CFDA # (If Federal Funds)
2007		**0**	**0**

Document ID # :	MMARS Code:	Amendment #: (If Applicable)	Program Type :	UFR Prog. # :
710007000000DMR00000	**0**	**00**	**#N/A**	**0**

UNIT RATE CALCULATION

1 . **Program Total Costs** **$** -

	Source	Amount
2a.(1) Program Offsets		-
Applied to occupancy and meals		-
2a.(2) Program Offsets		-
Applied to non-occupancy and meals		-
2a.(c) Other Offsets		-
		-
2b. Offsets for Non-Reimbursable Costs:		-

NOTE: Total reimbursable costs listed in line **2b** must be detailed on **ATTACHMENT 5** .

2 . SUBTOTAL OFFSETS (**Line 2A + Line 2B**) **($** - **)**

3 . Net Adjusted Program Costs (**LINE 1 minus LINE 2**) **$** -

4 . Total Program Capacity [0] 0 (# of Units) Bed / Day (Type of Unit)

5 . Share of Total Capacity Being Purchased by Contract - (# of units) 100.00% **(% of line 4)**

6 . Negotiated Utilization Factor, if any **100.00%**

7 . Adjusted Capacity Used To Establish Price (**LINE 4 x LINE 6**) - (# of Units)

8 . Unit Rate **(LINE 3 / LINE 7)** **$** -

9 . Maximum # of Billable Units (**LINE 5 x LINE 6**) -

MAXIMUM OBLIGATION CALCULATION

11 . FOR UNIT RATE : (**LINE 8 x LINE 9**)
FOR OTHER PRICE CALCULATION METHOD, ENTER OBLIGATION FROM LINE 10
FOR COST REIMBURSEMENT : ENTER REIMBURSABLE COST TOTAL FROM PROGRAM BUDGET

$ -

12 . Invoice Offset

Source	Amount
	-
	-
	-

12 . Subtotal **($** - **)**

13 . Program Maximum Obligation - Non - Capital Budget **(LINE 11 minus LINE 12)** **$** -

14 . Capital Budget (From Capital Budget Form), if applicable **$** -

15 . **TOTAL MAXIMUM OBLIGATION for Program (LINE 13 + Line 14)** **$** -

FOR INFORMATION ONLY : Other Revenue Sources (Only if % In LINE 5 is less than 100 %)

SOURCE	AMOUNT

FY 2007 Program Number 4

ATTACHMENT 1 : PROGRAM COVER PAGE

PROGRAM INFORMATION

Contractor / Provider Name :	Department Name : Department of Mental Retardation	
Program Type : #N/A	Document ID # : **710007000000DMR00000**	
Program Name : 0	Vendor Code Number :	CFDA # (If Federal Funds) 0
Program Address : 0	MMARS Program Code : 0	UFR Program # : 0
City / State / Zip : , 00000-	Other Reference Information (For Information Purposes Only) :	
Contact Person : **0** Telephone : **000-000-0000**	Contact Person : 0 Telephone : 000-000-0000	

RFR INFORMATION : ☐ Attached ☒ RFR Reference # : 0

☐ legislative exemption ☐ emergency ☐ collective purchase ☐ interim ☒ amendment

SCOPE OF SERVICES : ☐ Bidders Response Attached ☐ Description of Services Attached

TOTAL ANTICIPATED CONTRACT DURATION **January 0, 1900** to **January 0, 1900**

INITIAL DURATION : **January 0, 1900** to **January 0, 1900**

OPTIONS TO RENEW : _____ options to renew for _____ year (s) each option

FISCAL TERMS

PRICE ESTABLISHED THROUGH : (CHECK 1 , 2 , OR 3)

☐ **OPTION 1 : PRICE AGREEMENT** (list price)
$ _____
rate regulation (if any) _____

☐ **OPTION 2 : SUMMARY BUDGET** (* lines only)
☐ unit rate
☐ cost reimbursement
☐ other _____

☐ **OPTION 3 : COMPLETE BUDGET**
☐ unit rate
☐ cost reimbursement
☐ other _____

FUNDING SUMMARY

Prior Years FY	Prior Years Amount	Current Year FY	Current Year Amount	Future Years FY	Future Years Amount
	-	2007	-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
Total	-	**Total**	-	**Total**	-

Multi - Year Total : **$ 0.00**

CURRENT MAX OBLIGATION : $ 0.00.

UNIT RATE : $ - per **Bed / Day**

 # BILLABLE UNITS : -

ADDITIONAL PAYMENT OR PRICE SPECIFICATIONS :

Ready Payment Amount for SM01 Schedule = **$ 0.00**

Capital Budget Amount **$** 0.00

PURCHASE OF SERVICE - ATTACHMENT 3 : FISCAL YEAR PROGRAM BUDGET (# 4)

2007		0
FY	CONTRACTOR NAME	CFDA # (If Federal Funds)

Program Name :	Document ID # :	MMARS Code:	Amendment #:	Program Type :	UFR Prog. # :
0	710007000000DMR00000	0	0	#N/A	0

UFR Title #	Program Component Direct Care / Program Support Staff Overtime/Shift Differential & Relief (UFR Titles 101-141)	Current		Amended / Change		New		COST REIMBURSEMENT ONLY		
		FTE	Amount	FTE	Amount	FTE	Amount	** Offset	Source	Reimbursable Cost
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
	SUBTOTAL STAFF	-	-	-	-	-	-	-		-
150	Payroll Taxes	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
151	Fringe Benefits	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
T	**Total Direct Care / Program Staff**	-	-	-	-	-	-	-		-
Title	**OCCUPANCY**									
301	Program Facilities		-		-		-	-		-
***390	Fac. Oper/Main/Furn		-		-		-	-		-
T	**Total Occupancy**		-		-		-	-		-
UFR TITLE #	Other Direct Care / Program Support		**Amount**		**Amount**		**Amount**	**Offset**	**Source**	**Reimbursable Cost**
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
T	**Total Other Direct Care / Program Support**	-	-	-	-	-	-	-		-
Title	**Direct Admin Expenses**									
216	Program Support		-		-		-	-		-
***410 & 390	Other Direct Administrative Expenses		-		-		-	-		-
T	**Total Direct Admin Expenses**		-		-		-	-		-
T	**Subtotal Program Costs**		-		-		-	-		-
T	Agency Admin. Support Allocation	#DIV/0!	-		-	#DIV/0!	-	-		-
T	**PROGRAM TOTAL**	-	-	-	-	-	-	-		-

Commercial Fee, if applicable (for informational purposes only; not to be included in the price paid by the Commonwealth) % ____ $ ____ : **N/A for Cost Reimbursement**

** Non-reimbursable costs must be shown on the detail Attachment 5 when the program is subject to the provisions of Federal OMB Circular A - 122 and / or 808 CMR 1.00.

**A. $ ____ Subtotal of offsets which are for non-reimbursable costs.

*** Contractor's Board approved capitalization level relative to any negotiated expense costs in lines 208, 215, 390 or 410 is $ ____

PURCHASE OF SERVICE
ATTACHMENT 4: RATE CALCULATION / MAXIMUM OBLIGATION CALCULATION PAGE

Program Number 4

FY :	Contractor Name :	Program Name :	CFDA # (If Federal Funds)
2007		**0**	**0**

Document ID # :	MMARS Code:	Amendment #: (If Applicable)	Program Type :	UFR Prog. # :
710007000000DMR00000	**0**	**00**	**#N/A**	**0**

UNIT RATE CALCULATION

1 . **Program Total Costs** **$** -

	Source	Amount
2a.(1) Program Offsets		-
Applied to occupancy and meals		-
2a.(2) Program Offsets		-
Applied to non-occupancy and meals		-
2a.(c) Other Offsets		-
		-
2b. Offsets for Non-Reimbursable Costs:		-

NOTE: Total reimbursable costs listed in line **2b** must be detailed on **ATTACHMENT 5** .

2 . SUBTOTAL OFFSETS (**Line 2A + Line 2B**) **($** - **)**

3 . Net Adjusted Program Costs (**LINE 1 minus LINE 2**) **$** -

4 . Total Program Capacity 0 0 (# of Units) Bed / Day (Type of Unit)

5 . Share of Total Capacity Being Purchased by Contract - (# of units) 100.00% **(% of line 4)**

6 . Negotiated Utilization Factor, if any **85.00%**

7 . Adjusted Capacity Used To Establish Price (**LINE 4 x LINE 6**) - (# of Units)

8 . Unit Rate **(LINE 3 / LINE 7)** **$** -

9 . Maximum # of Billable Units (**LINE 5 x LINE 6**) -

MAXIMUM OBLIGATION CALCULATION

11 . FOR UNIT RATE : (**LINE 8 x LINE 9**)
FOR OTHER PRICE CALCULATION METHOD, ENTER OBLIGATION FROM LINE 10
FOR COST REIMBURSEMENT : ENTER REIMBURSABLE COST TOTAL FROM PROGRAM BUDGET

$ -

12 . Invoice Offset

Source	Amount
	-
	-
	-

12 . Subtotal **($** - **)**

13 . Program Maximum Obligation - Non - Capital Budget **(LINE 11 minus LINE 12)** **$** -

14 . Capital Budget (From Capital Budget Form), if applicable **$** -

15 . **TOTAL MAXIMUM OBLIGATION for Program (LINE 13 + Line 14)** **$** -

FOR INFORMATION ONLY : Other Revenue Sources (Only if % In LINE 5 is less than 100 %)

SOURCE	AMOUNT

FY 2007 Program Number 5

ATTACHMENT 1 : PROGRAM COVER PAGE

PROGRAM INFORMATION

Contractor / Provider Name :	Department Name : Department of Mental Retardation	
Program Type : #N/A	Document ID # : **710007000000DMR00000**	
Program Name : 0	Vendor Code Number :	CFDA # (If Federal Funds) 0
Program Address : 0	MMARS Program Code : 0	UFR Program # : 0
City / State / Zip : , 00000-	Other Reference Information (For Information Purposes Only) :	
Contact Person : **0** Telephone : **000-000-0000**	Contact Person : 0 Telephone : 000-000-0000	

RFR INFORMATION : ☐ Attached ☒ RFR Reference # : 0

☐ legislative exemption ☐ emergency ☐ collective purchase ☐ interim ☒ amendment

SCOPE OF SERVICES : ☐ Bidders Response Attached ☐ Description of Services Attached

TOTAL ANTICIPATED CONTRACT DURATION **January 0, 1900** to **January 0, 1900**

INITIAL DURATION : **January 0, 1900** to **January 0, 1900**

OPTIONS TO RENEW : _____ options to renew for _____ year (s) each option

FISCAL TERMS

PRICE ESTABLISHED THROUGH : (CHECK 1 , 2 , OR 3)

☐ **OPTION 1 : PRICE AGREEMENT** (list price)
$ _____
rate regulation (if any) _____

☐ **OPTION 2 : SUMMARY BUDGET** (* lines only)
☐ unit rate
☐ cost reimbursement
☐ other _____

☐ **OPTION 3 : COMPLETE BUDGET**
☐ unit rate
☐ cost reimbursement
☐ other _____

FUNDING SUMMARY

Prior Years FY	Prior Years Amount	Current Year FY	Current Year Amount	Future Years FY	Future Years Amount
	-	2007	-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
Total	-	**Total**	-	**Total**	-

Multi - Year Total : **$ 0.00**

CURRENT MAX OBLIGATION : $ 0.00.

UNIT RATE : $ - per **Bed / Day**

 # BILLABLE UNITS : -

ADDITIONAL PAYMENT OR PRICE SPECIFICATIONS :

Ready Payment Amount for SM01 Schedule = **$ 0.00**

Capital Budget Amount $ 0.00

PURCHASE OF SERVICE - ATTACHMENT 3 : FISCAL YEAR PROGRAM BUDGET (# 5)

2007 | 0

FY | CONTRACTOR NAME | CFDA # (If Federal Funds)

Program Name :	Document ID # :	MMARS Code:	Amendment #:	Program Type :	UFR Prog. # :
0	710007000000DMR00000	0	0	#N/A	0

UFR Title #	Program Component Direct Care / Program Support Staff Overtime/Shift Differential & Relief (UFR Titles 101-141)	Current		Amended / Change		New		COST REIMBURSEMENT ONLY		
		FTE	Amount	FTE	Amount	FTE	Amount	** Offset	Source	Reimbursable Cost
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
	SUBTOTAL STAFF	-	-	-	-	-	-	-		-
150	Payroll Taxes	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
151	Fringe Benefits	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
T	**Total Direct Care / Program Staff**	-	-	-	-	-	-	-		-
Title	**OCCUPANCY**									
301	Program Facilities		-		-		-	-		-
***390	Fac. Oper/Main/Furn		-		-		-	-		-
T	**Total Occupancy**		-		-		-	-		-
UFR TITLE #	Other Direct Care / Program Support		**Amount**		**Amount**		**Amount**	**Offset**	**Source**	**Reimbursable Cost**
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
T	**Total Other Direct Care / Program Support**	-	-	-	-	-	-	-		-
Title	**Direct Admin Expenses**									
216	Program Support		-		-		-	-		-
***410 & 390	Other Direct Administrative Expenses		-		-		-	-		-
T	**Total Direct Admin Expenses**		-		-		-	-		-
T	**Subtotal Program Costs**		-		-		-	-		-
T	Agency Admin. Support Allocation	#DIV/0!	-		-	#DIV/0!	-	-		-
T	**PROGRAM TOTAL**	-	-	-	-	-	-	-		-

Commercial Fee, if applicable (for informational purposes only; not to be included in the price paid by the Commonwealth) % ____ $ ____ : **N/A for Cost Reimbursement**

** Non-reimbursable costs must be shown on the detail Attachment 5 when the program is subject to the provisions of Federal OMB Circular A - 122 and / or 808 CMR 1.00.

**A. $ ____ Subtotal of offsets which are for non-reimbursable costs.

*** Contractor's Board approved capitalization level relative to any negotiated expense costs in lines 208, 215, 390 or 410 is $ ____

PURCHASE OF SERVICE

ATTACHMENT 4: RATE CALCULATION / MAXIMUM OBLIGATION CALCULATION PAGE

Program Number 5

FY :	Contractor Name :	Program Name :	CFDA # (If Federal Funds)
2007		**0**	**0**

Document ID # :	MMARS Code:	Amendment #: (If Applicable)	Program Type :	UFR Prog. # :
710007000000DMR00000	**0**	**00**	**#N/A**	**0**

UNIT RATE CALCULATION

1 . **Program Total Costs** **$** -

	Source	Amount
2a.(1) Program Offsets		-
Applied to occupancy and meals		-
2a.(2) Program Offsets		-
Applied to non-occupancy and meals		-
2a.(c) Other Offsets		-
		-
2b. Offsets for Non-Reimbursable Costs:		-

NOTE: Total reimbursable costs listed in line **2b** must be detailed on **ATTACHMENT 5** .

2 . SUBTOTAL OFFSETS (**Line 2A + Line 2B**) **($** - **)**

3 . Net Adjusted Program Costs (**LINE 1 minus LINE 2**) **$** -

4 . Total Program Capacity [0] 0 (# of Units) Bed / Day (Type of Unit)

5 . Share of Total Capacity Being Purchased by Contract - (# of units) 100.00% **(% of line 4)**

6 . Negotiated Utilization Factor, if any **100.00%**

7 . Adjusted Capacity Used To Establish Price (**LINE 4 x LINE 6**) - (# of Units)

8 . Unit Rate **(LINE 3 / LINE 7)** **$** -

9 . Maximum # of Billable Units (**LINE 5 x LINE 6**) -

MAXIMUM OBLIGATION CALCULATION

11 . FOR UNIT RATE : (**LINE 8 x LINE 9**)
FOR OTHER PRICE CALCULATION METHOD, ENTER OBLIGATION FROM LINE 10
FOR COST REIMBURSEMENT : ENTER REIMBURSABLE COST TOTAL FROM PROGRAM BUDGET

$ -

12 . Invoice Offset

Source	Amount
	-
	-
	-

12 . Subtotal **($** - **)**

13 . Program Maximum Obligation - Non - Capital Budget **(LINE 11 minus LINE 12)** **$** -

14 . Capital Budget (From Capital Budget Form), if applicable **$** -

15 . **TOTAL MAXIMUM OBLIGATION for Program (LINE 13 + Line 14)** **$** -

FOR INFORMATION ONLY : Other Revenue Sources (Only if % In LINE 5 is less than 100 %)

SOURCE	AMOUNT

FY 2007 Program Number 6

ATTACHMENT 1 : PROGRAM COVER PAGE

PROGRAM INFORMATION

Contractor / Provider Name :	Department Name : Department of Mental Retardation	
Program Type : #N/A	Document ID # : **710007000000DMR00000**	
Program Name : 0	Vendor Code Number :	CFDA # (If Federal Funds) 0
Program Address : 0	MMARS Program Code : 0	UFR Program # : 0
City / State / Zip : , 00000-	Other Reference Information (For Information Purposes Only) :	
Contact Person : **0** Telephone : **000-000-0000**	Contact Person : 0 Telephone : 000-000-0000	

RFR INFORMATION : ☐ Attached ☒ RFR Reference # : 0

☐ legislative exemption ☐ emergency ☐ collective purchase ☐ interim ☒ amendment

SCOPE OF SERVICES : ☐ Bidders Response Attached ☐ Description of Services Attached

TOTAL ANTICIPATED CONTRACT DURATION **January 0, 1900** to **January 0, 1900**

INITIAL DURATION : **January 0, 1900** to **January 0, 1900**

OPTIONS TO RENEW : _____ options to renew for _____ year (s) each option

FISCAL TERMS

PRICE ESTABLISHED THROUGH : (CHECK 1 , 2 , OR 3)

☐ **OPTION 1 : PRICE AGREEMENT** (list price)
$ _____
rate regulation (if any) _____

☐ **OPTION 2 : SUMMARY BUDGET** (* lines only)
☐ unit rate
☐ cost reimbursement
☐ other _____

☐ **OPTION 3 : COMPLETE BUDGET**
☐ unit rate
☐ cost reimbursement
☐ other _____

FUNDING SUMMARY

Prior Years FY	Prior Years Amount	Current Year FY	Current Year Amount	Future Years FY	Future Years Amount
	-	2007	-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
	-		-		-
Total	-	**Total**	-	**Total**	-

Multi - Year Total : **$ 0.00**

CURRENT MAX OBLIGATION : $ 0.00. **UNIT RATE : $ -** per **Bed / Day** **# BILLABLE UNITS : -**

ADDITIONAL PAYMENT OR PRICE SPECIFICATIONS : ***Ready Payment Amount for SM01 Schedule =*** **$ 0.00**

Capital Budget Amount **$** 0.00

PURCHASE OF SERVICE - ATTACHMENT 3 : FISCAL YEAR PROGRAM BUDGET (# 6)

2007		0
FY	CONTRACTOR NAME	CFDA # (If Federal Funds)

Program Name :	Document ID # :	MMARS Code:	Amendment #:	Program Type :	UFR Prog. # :
0	710007000000DMR00000	0	0	#N/A	0

UFR Title #	Program Component Direct Care / Program Support Staff Overtime/Shift Differential & Relief (UFR Titles 101-141)	Current		Amended / Change		New		COST REIMBURSEMENT ONLY		
		FTE	Amount	FTE	Amount	FTE	Amount	** Offset	Source	Reimbursable Cost
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
	SUBTOTAL STAFF	-	-	-	-	-	-	-		-
150	Payroll Taxes	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
151	Fringe Benefits	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	-		-
T	**Total Direct Care / Program Staff**	-	-	-	-	-	-	-		-
Title	**OCCUPANCY**									
301	Program Facilities		-		-		-	-		-
***390	Fac. Oper/Main/Furn		-		-		-	-		-
T	**Total Occupancy**		-		-		-	-		-
UFR TITLE #	Other Direct Care / Program Support		**Amount**		**Amount**		**Amount**	**Offset**	**Source**	**Reimbursable Cost**
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
-	-		-		-		-	-		-
T	**Total Other Direct Care / Program Support**	-	-	-	-	-	-	-		-
Title	**Direct Admin Expenses**									
216	Program Support		-		-		-	-		-
***410 & 390	Other Direct Administrative Expenses		-		-		-	-		-
T	**Total Direct Admin Expenses**		-		-		-	-		-
T	**Subtotal Program Costs**		-		-		-	-		-
T	Agency Admin. Support Allocation	#DIV/0!	-		-	#DIV/0!	-	-		-
T	**PROGRAM TOTAL**	-	-	-	-	-	-	-		-

Commercial Fee, if applicable (for informational purposes only; not to be included in the price paid by the Commonwealth) % ____ $ ____ : **N/A for Cost Reimbursement**

** Non-reimbursable costs must be shown on the detail Attachment 5 when the program is subject to the provisions of Federal OMB Circular A - 122 and / or 808 CMR 1.00.

**A. $ ____ Subtotal of offsets which are for non-reimbursable costs.

*** Contractor's Board approved capitalization level relative to any negotiated expense costs in lines 208, 215, 390 or 410 is $ ____

PURCHASE OF SERVICE

ATTACHMENT 4: RATE CALCULATION / MAXIMUM OBLIGATION CALCULATION PAGE

Program Number 6

FY :	Contractor Name :	Program Name :	CFDA # (If Federal Funds)
2007		**0**	**0**

Document ID # :	MMARS Code:	Amendment #: (If Applicable)	Program Type :	UFR Prog. # :
710007000000DMR00000	**0**	**00**	**#N/A**	**0**

UNIT RATE CALCULATION

1 . **Program Total Costs** **$** -

	Source	Amount
2a.(1) Program Offsets		-
Applied to occupancy and meals		-
2a.(2) Program Offsets		-
Applied to non-occupancy and meals		-
2a.(c) Other Offsets		-
		-
2b. Offsets for Non-Reimbursable Costs:		-

NOTE: Total reimbursable costs listed in line **2b** must be detailed on **ATTACHMENT 5** .

2 . SUBTOTAL OFFSETS (**Line 2A + Line 2B**) **($** - **)**

3 . Net Adjusted Program Costs (**LINE 1 minus LINE 2**) **$** -

4 . Total Program Capacity [0] 0 (# of Units) Bed / Day (Type of Unit)

5 . Share of Total Capacity Being Purchased by Contract - (# of units) 100.00% **(% of line 4)**

6 . Negotiated Utilization Factor, if any **85.00%**

7 . Adjusted Capacity Used To Establish Price (**LINE 4 x LINE 6**) - (# of Units)

8 . Unit Rate **(LINE 3 / LINE 7)** **$** -

9 . Maximum # of Billable Units (**LINE 5 x LINE 6**) -

OTHER PRICE CALCULATION METHOD

MAXIMUM OBLIGATION CALCULATION

11 . FOR UNIT RATE : (**LINE 8 x LINE 9**)

FOR OTHER PRICE CALCULATION METHOD, ENTER OBLIGATION FROM LINE 10

FOR COST REIMBURSEMENT : ENTER REIMBURSABLE COST TOTAL FROM PROGRAM BUDGET

$ -

12 . Invoice Offset

Source	Amount
	-
	-
	-

12 . Subtotal **($** - **)**

13 . Program Maximum Obligation - Non - Capital Budget **(LINE 11 minus LINE 12)** **$** -

14 . Capital Budget (From Capital Budget Form), if applicable **$** -

15 . **TOTAL MAXIMUM OBLIGATION for Program (LINE 13 + Line 14)** **$** -

FOR INFORMATION ONLY : Other Revenue Sources (Only if % In LINE 5 is less than 100 %)

SOURCE	AMOUNT

PURCHASE OF SERVICE ATTACHMENT 6: CAPITAL BUDGET:

For Purchase of Capital Assets With Commonwealth Funds

FY :	Contractor Name :	Program Name :	CFDA # (If Federal Funds)
2007			

Document ID # :	Program Code:	Amendment #: (If Applicable)	Program Type :	UFR Prog. # :
710007000000DMR00000		0		

Items To Be Purchased	Need For Item	Quantity	Estimated Unit Cost	Estimated Total Cost
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-

Total Cost: $ -

DEPARTMENT USE ONLY: Check the appropriate box:

Capital items purchased by the Contractor: ☐

Capital items purchased by the Commonwealth (object code M11): ☐

Only capital items, as defined in 808 CMR 1.05(4)(a), may be procured through a capital budget with Commonwealth funds. The following are not eligible to be procured through this capital budget: capital items defined under 808 CMR 1.05(4)(b) which includes capital items that are not moveable, an asset or group of assets that are below the Contractor's capitalization level, or items not approved by the Department. Title to all capital items purchased by the Contractor through this capital budget shall vest with the Contractor (with certain restrictions). Title to all capital items purchased by the Commonwealth through this capital budget and the M11 object code shall vest with the Commonwealth.

* Pursuant to the provisions of OMB Circular A-122 a capital budget that utilizes federal grant funds to acquire capital items for use in programs receiving any federal grant funds may not be used unless the Department receives prior written approval from the Federal awarding agency(ies). Capital items of furnishings and equipment purchased with Commonwealth funds that are to be owned by the Contractor and used in programs receiving federal grant funds may only be acquired using a capital budget if the revenue and expense associated with the capital items are budgeted and disclosed in the UFR as a separate revenue and cost category of the program.

Use of assets acquired with Commonwealth funds should be clearly disclosed in the financial statements. The asset(s) should be disclosed on the UFR Balance Sheet in the plant fund if the Contractor holds title or in the custodian fund if the Commonwealth holds title. The revenue derived from the capital budget when the asset is purchased should be disclosed in program services on the UFR Statement of Activities and in the appropriate program(s) on the Supplemental Revenue Schedule A. Capital assets, whether owned by the Contractor or the Commonwealth, should be depreciated and disclosed in Supplemental Expense Schedule B and Schedule B-1 as a non-reimbursable cost when incurred, using the schedule of service lives issued by the Operational Services Division. See also 808 CMR 1.05(2)(d).

The assets furnished through a capital budget must be labeled and kept on file in the Contractor's written inventory, which notes the number and description of assets, source of funding, acquisition cost and location of assets, pursuant to 808 CMR 1.04(5). In addition, the Contractor must follow disposition standards in 808 CMR 1.04(5).

I,_____, an authorized signatory for _____ (the Contractor), hereby certify that the Contractor's capitalization level established for financial statement purposes by the board of directors is: an asset or group of assets of non-expendable personal property having a useful life of more than one year and an acquisition cost of $_____.

_____ (Signature)

_____ (Title)

_____ (Date)

d through a capital budget with Commonwealth funds. The following
s defined under 808 CMR 1.05(4)(b) which includes capital items that
actor's capitalization level, or items not approved by the Department.
l budget shall vest with the Contractor (with certain restrictions). Title
l budget and the M11 object code shall vest with the Commonwealth.

t that utilizes federal grant funds to acquire capital items for use in
Department receives prior written approval from the Federal awarding
ith Commonwealth funds that are to be owned by the Contractor and
using a capital budget if the revenue and expense associated with the
ue and cost category of the program.

closed in the financial statements. The asset(s) should be disclosed on
r in the custodian fund if the Commonwealth holds title. The revenue
disclosed in program services on the UFR Statement of Activities and
dule A. Capital assets, whether owned by the Contractor or the
l Expense Schedule B and Schedule B-1 as a non-reimbursable cost
onal Services Division. See also 808 CMR 1.05(2)(d).

t on file in the Contractor's written inventory, which notes the number
on of assets, pursuant to 808 CMR 1.04(5). In addition, the Contractor

gnatory for _____ (the
vel established for financial statement purposes by the board of
onal property having a useful life of more than one year and an
$_____.

ATTACHMENT 2 : PERFORMANCE MEASURES

Fiscal Year :	Contractor Name :	Program Name :	CFDA # (If Federal Funds)
2007			

Document ID # :	Program Code :	Amendment # : (If Applicable)	Program Type :	UFR Prog. # :
710007000000DMR00000		**0**		

PERFORMANCE MEASURES

PROGRAM OUTCOMES	MEASURE	GOAL * Year 1	Year 2	Year 3	Year 4	Year 5
1						
2						
3						
4						
5						
PROGRAM OUTPUTS	**MEASURE**	**GOAL * Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
1						
2						
3						
4						
5						
PROGRAM EFFICIENCY	**MEASURE**	**GOAL * Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
1						
2						
3						
4						
5						
PROGRAM EFFECTIVENESS	**MEASURE**	**GOAL * Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
1						
2						
3						
4						
5						

*** Attach additional years, if appropriate**

ATTACHMENT 5 : NON - REIMBURSABLE COST PROGRAM OFFSET SCHEDULE

FY :	Contractor Name :	Program Name :	CFDA # (If Federal Funds)
2007			

Document ID # :	Program Code:	Amendment #: (If Applicable)	Program Type :	UFR Prog. # :
710007000000DMR00000		**0**		

If Applicable

Program Component	State and / or Federal Reg.	Non-Reimbursable Cost	Source of Funds for Offset	Related Party (Yes / No)	Name of Related Party
1. Direct Care / Program Support Staff					
		$ -			
		$ -			
		$ -			
2. Other Direct Care					
		$ -			
		$ -			
		$ -			
		$ -			
		$ -			
		$ -			
3. Occupancy					
		$ -			
		$ -			
		$ -			
		$ -			
		$ -			
		$ -			
4. Administrative Support					
		$ -			
		$ -			
		$ -			
		$ -			
		$ -			
		$ -			

*** Subtotal** $ -

* Subtotal must reconcile to line 2b on the Rate Calculation Page for Unit Rate / Accommodations Purchase budgets, or to line A on the bottom of the budget page for Cost Reimbursement budgets .

Lookup Tables

Regions

Region Number	Region Name	Region Street	Region City	Region State
1	Central/West Regional Office	171 State Avenue	Palmer	MA
2	Central/West Regional Office	171 State Avenue	Palmer	MA
3	Northeast	P O Box A	Hathorne	MA
5	Southeast	68 North Main Street	Carver	MA
6	Metro Region- Fernald Center	200 Trapelo Road	Waltham	MA

#	UFR TITLE DESCRIPTION
101	Program Manager
102	Program Director
103	Asst. Program Director
104	Supvsr. Professional
105	Physician
106	Physician's Asst.
107	Reg. Nurse - Masters
108	Registered Nurse
109	Licensed Prac. Nurse
110	Pharmacist
111	Occupational Therapist
112	Physical Therapist
113	Speech /Lang. Pathol.,Audiolgist
114	Dietician/Nutritionist
115	Spec. Educ. Teacher
116	Teacher
117	Day Care Director
118	Day Care Lead Teacher
119	Day Care Teacher
120	Day Care Asst. Teach./Aide
121	Psychiatrist
122	Psychologist-Doctorate
123	Psychologist-Masters
124	Social Worker-LICSW
125	Social Worker-LCSW
126	Social Worker-LSW
127	Licensed Conselor
128	Cert. Voc. Rehab. Couns.
129	Cert. Sub. Abuse Counselor
130	Counselor
131	Case Worker / Mgr. - Mstrs.
132	Case Worker / Manager
133	D. C. / Prog. Staff Super.
134	D. C./ Prog. Staff III
135	D. C./ Prog. Staff II
136	D. C./ Prog. Staff I
137	Pgrm. Secretarial / Clerical
138	Program Support
139	Direct Care Overtime

141	Relief

Activity Code

Activity Code	*ACTIVITY CODE NAME*
3150	Placement Services
3153	Residential Services
3161	Residential Services MSA
3163	Community Based Day Supports
3166	Day Supports MSA
3168	Employment Supports Services
3170	Clinical Team
3174	Support Services MSA
3176	Family Support Services
3177	Individual Support Services
3182	Emergency Residential Services
3196	Transportation
3197	Employment Supports MSA
3202	Medical Services
3282	Personal Agent Services
3283	Assistive Technology
3284	Transitional Services
3285	Day Habilitation Supplement
3286	Community Habilitation Supports

Short #	Areas	Names
		Central Office
00	1000	Region 1
10	2100	Berkshire
11	2110	Franklin Hampshire
12	2120	Springfield/Westfield
14	2140	Hoyloke Chicopee
15	2150	Springfield/Westfield
16	2160	Region 2
20	2200	North Central
21	2210	South Valley
22	2220	Monson Dev Center
23	3230	Worcester
24	2240	Region 3
30	2300	Lowell
31	2310	Merrimack
32	2320	Glavin Reg Center
33	3330	Central Middlesex
34	2340	North Shore
35	2350	Metro North
38	2380	Hogan Berry Reg Center
43	3430	Hogan Berry Reg Center
43	4300	Region 5 SRS

45	4500	Region 6 SRS
46	4600	Region 5
50	2500	Brockton
52	2520	Fernald Dev Center
53	3530	Taunton Attleboro
54	2540	Fall River
55	2550	New Bedford
56	2560	Cape Cod Islands
57	2570	Plymouth
58	2580	South Coastal
59	2590	Region 6
60	2600	Charles River West
61	2610	Dorchester Fuller
62	2620	Dever Reg Center
63	3630	Middlesex West
66	2660	Newton South Norfolk
67	2670	South Coastal
69	2690	Wrentham Dev Center
73	3730	Templeton Dev Center
83	3830	

201	Direct Care Consultant
202	Temporary Help
203	Reimb/Stipends
204	Staff Training
205	Staff Mileage/Travel
206	Subcontract Dir. Care
207	Meals
208	Contracted Client Trans.
208.1	Vehicle Expenses***
208.2	Vehicle Depreciation***
209	Incid. Health/Med Care
210	Medicine /Pharmacy
211	Client Per. Allowances
212	Prov. Of Material Good
214.1	Direct Client Wages
214.2	Other Commercial Prod. & Svs.
215	Program Supplies/Mat.***

Region Zip
01069
01069
01937
02330
02451